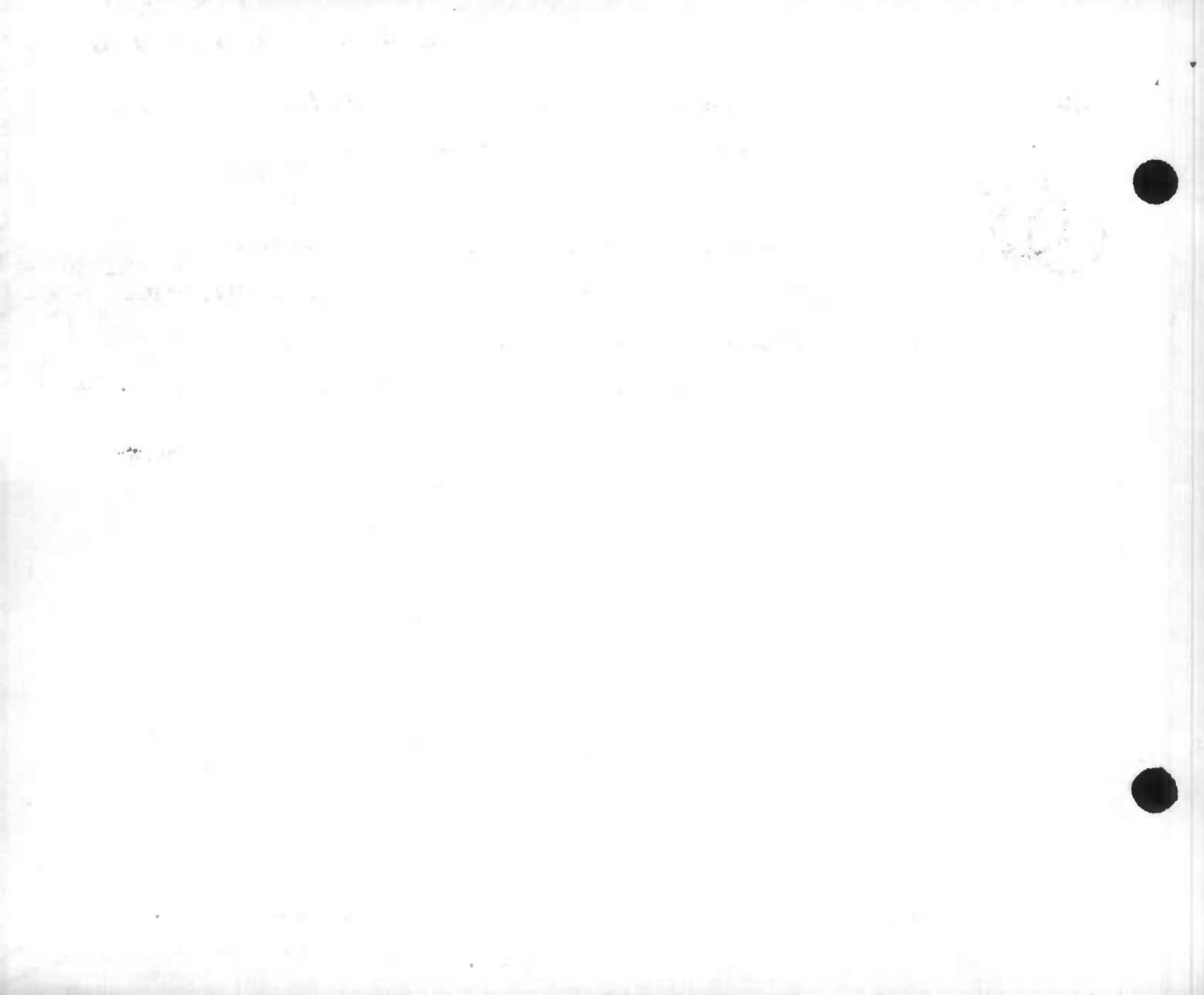


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25096				
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)			Wanda			Corena			Baker			9/25/84				1:40A M
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH 4 DAY 7 YEAR 95			89			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? America			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.							
10. CITY OR TOWN OF DEATH Chestertown, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MD		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 0.0. Box 217, Heather Heights 21620								
14. FATHER'S NAME FIRST Edward MIDDLE Ellsworth LAST Flemings			15. MOTHER'S MAIDEN NAME FIRST Cora MIDDLE Ann LAST Harnish													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a			17. INFORMANT Peggy Morin			Heather Heights Chestertown, Md. 21620							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE RENAL FAILURE																
DUE TO, OR AS A CONSEQUENCE OF (c) ANEMOSCLEROTIC CEREBROVASCULAR DISEASE																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____										
22a. I certify that (I) (this hospital) attended the deceased from 9/12/84 to 9/25/84, that (I) (we) last saw the deceased alive on 9/24/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED				
22b. SIGNATURE Virginia A. Collier												DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS PO BOX 599 CHESTERTOWN, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/28/84			23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			23d. LOCATION CITY OR TOWN Hagerstown, Md. COUNTY STATE							
24. FUNERAL DIRECTOR NAME H. Wells Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR SEP 26 1984			25b. REGISTRAR'S SIGNATURE John Davidson Pendell							
25c. ADDRESS Chestertown, Md.																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's office. Please remove carbon papers. Pages 1 and 2 should be filed and written 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be summoned at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25097
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
ARDENA			GROCE			9-16-84			8:30 P.M.	
3. SEX FEMALE			4 RACE BLACK			5. DATE OF BIRTH MUNTH DAY YEAR JUNE 21, 1909			6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH KENT	
10. CITY OR TOWN OF DEATH CHESTERLAWN			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENT & QUEEN ANNE'S HOSP.			12a. USUAL OCCUPATION LABOR			12b. KIND OF BUSINESS OR INDUSTRY VARIOUS	
13a. STATE Md			13b. COUNTY KENT			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE R.F.C. 21661	
14. FATHER'S NAME LAST MIDDLE LAST Louis JONES			15. MOTHER'S MAIDEN NAME F.D.A. COOPER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220.26.3059			17. INFORMANT Mr. Thomas M. GROCE R.F.C. #3 CHESTER TOWNSHIP, MD.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) unknown - possible abdominal viscera perforat.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) pancreatitis						3 days	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22b. I certify that (I) (was hospital) attended the deceased from 9-16-84, 1984, to 9-16-84, 1984, that (I) (did) (did) (did) view the body after death.										
22b. SIGNATURE Wayne D. Segar, M.D.			DEGREE			22c. DATE SIGNED 9/18/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne D. Segar, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/22/1984			23c. NAME OF CEMETERY OR CREMATORIAL Aaron Cem.			23d. LOCATION STREET CITY OR TOWN COUNTY STATE Rock Hall, Kent, Md.	
24. FUNERAL DIRECTOR NAME Katherine Wells			ADDRESS Chesterlawn			25a. DATE REC'D. BY REGISTRAR SEP 19 1984			25b. REGISTRAR'S SIGNATURE John Anderson, Jr.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

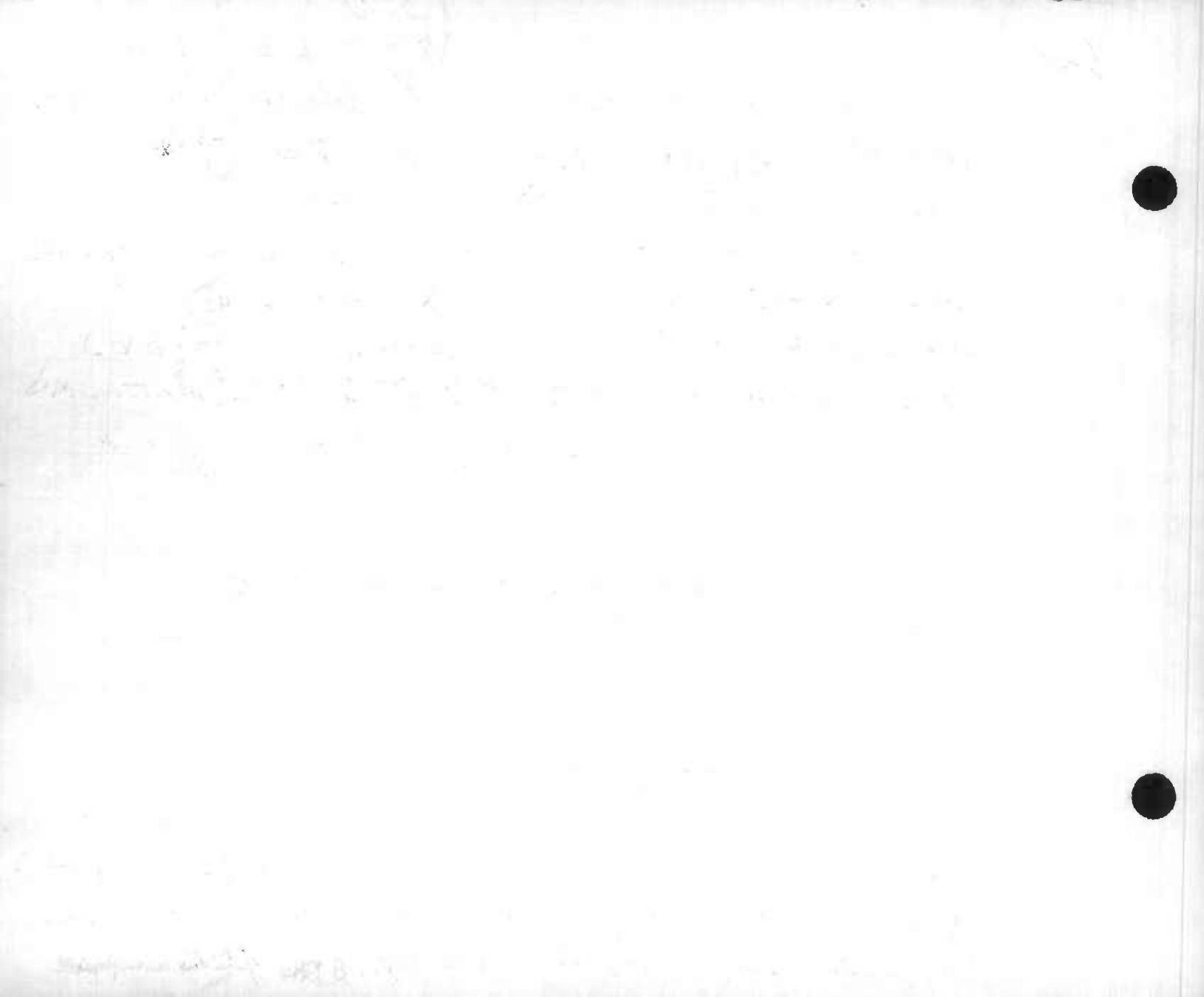
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25098	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HOWARD B. HADAWAY						Sept. 17, 1984						P 7	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			white	Aug. 1, 1912			72			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.	
Maryland			USA						Kent			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Chestertown			at home Rte # 20			Supervisor Street Maintenance							
13. STATE			14. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Md.			Kent			XX			RFD Rte # 20 21620				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE			LAST		
Howard W. Hadaway					Pearl			Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
no			214 16 4031			Estel B. Hadaway Chestertown, Md.			RFD Rte 20				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.I.D.													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
DIABETES MELLITUS													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <input type="checkbox"/> (the) hospital attended the deceased from MAY 19 67 to SEPT 17 1984, that (I) <input type="checkbox"/> lost saw the deceased alive on 7 Aug 1984 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>Harry Paul Ross MD</i>			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-18-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Chestertown, Md.							
Harry Paul Ross													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/20/84			23c. NAME OF CEMETERY OR CREMATORIUM Chester Cem.			23d. LOCATION Chestertown, Md. 21620				
Burial													
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR SEP 21 1984			25b. REGISTRAR'S SIGNATURE <i>Julia Wilson</i>							
J.W. Wells			ADDRESS Chestertown, Md.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25099	
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR September 8, 1984							2b. HOUR 5:10 P.M.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH MONTH DAY YEAR AUG. 31, 1908			6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		
3. SEX M A E			4. RACE B L A C K			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.			9. BALTIMORE CITY OR COUNTY OF DEATH Kent		
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HABOUR			12b. KIND OF BUSINESS OR INDUSTRY VARIOUS		
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Hutchins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANE Gibbs			13e. STREET ADDRESS / ZIP CODE R.F.D #3 21620		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 215-26-4989			17. INFORMANT Mrs. Rose Hutchins			ADDRESS 6 PO #2 Chestertown MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus (saddle)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)								
			(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). Lower GI Bleeding 2° to Diverticulitis, HSP by history, ASCVD											
19a. DATE OF OPERATION 8/8/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED lower GI Bleeding			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 8 1984 to Sept 8 1984 , that (I) (we) last saw the deceased alive on above (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Susan K. Ross, M.D. DEGREE											
22c. ATTENDING PHYSICIAN Susan K. Ross, M.D.			22d. MEDICAL DIRECTOR Susan K. Ross, M.D.			22e. STAFF PHYSICIAN Susan K. Ross, M.D.			22f. DATE SIGNED 9/17/84		
23a. BURIAL, CREMATION, REMOVAL (S) Burial			23b. DATE 9/15/1984			23c. NAME OF CEMETERY, OR CREMATORIAL Roseville Cem.			23d. LOCATION CITY OR TOWN Chestertown		
24. FUNERAL DIRECTOR Kenneth Wally			ADDRESS Chestertown			25a. DATE REC'D. BY REGISTRAR SEP 18 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

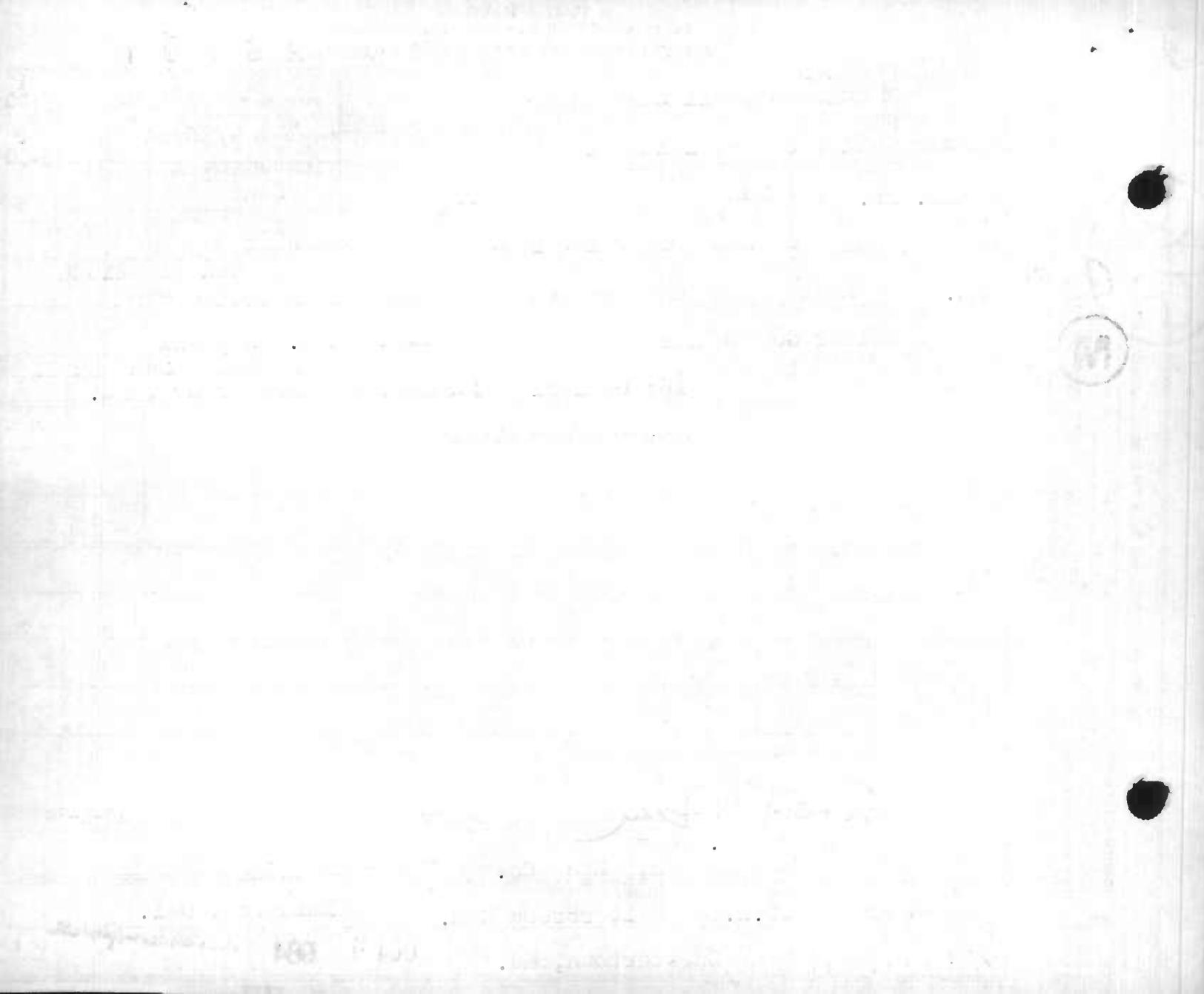
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												25100 REG. NO.		
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR									2b. HOUR A.M. 10:50		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST					
Erin Nicole Mangels														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			White			MONTH 9 DAY 15 YEAR 84			YRS.			1 50		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			USA						Kent County					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (# NOT IN SUCH FACILITY, ONE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown			Kent and Queen Anne's Hosp.			Nurse								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Kent			Rock Hall						RD #2, Box 74 21620		
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME					
Carl			Black			mangels			Kathleen			Delores Kelley		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			-			mother			RD #2 Box 74 Rock Hall					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Respiratory failure														
DUE TO, OR AS A CONSEQUENCE OF (b) extreme prematurity (gestational age) 25 weeks														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE John L. Morgan												DEGREE MD		
22c MEDICAL PROFESSION ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												DATE SIGNED 9/15/84		
22d. MEDICAL PROFESSION ICIAN'S NAME (TYPE OR PRINT) John L. Morgan			22e ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REBURIAL (SPECIFY)			23b. DATE 9-16-84			23c. NAME OF CEMETERY OR CREMATORIAL KENT + QUEEN ANNE'S			23d. LOCATION CITY OR TOWN CHESTERTOWN MD					
24. FUNERAL DIRECTOR NAME John L. Morgan			ADDRESS											
25. DATE OF DEATH SEP 20 1984												26. RAPID REGISTRATION Signature Julia Burdon		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH CROWN PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

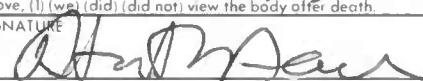
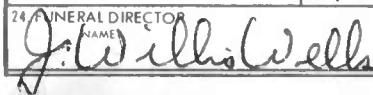
MEDICAL CERTIFICATION

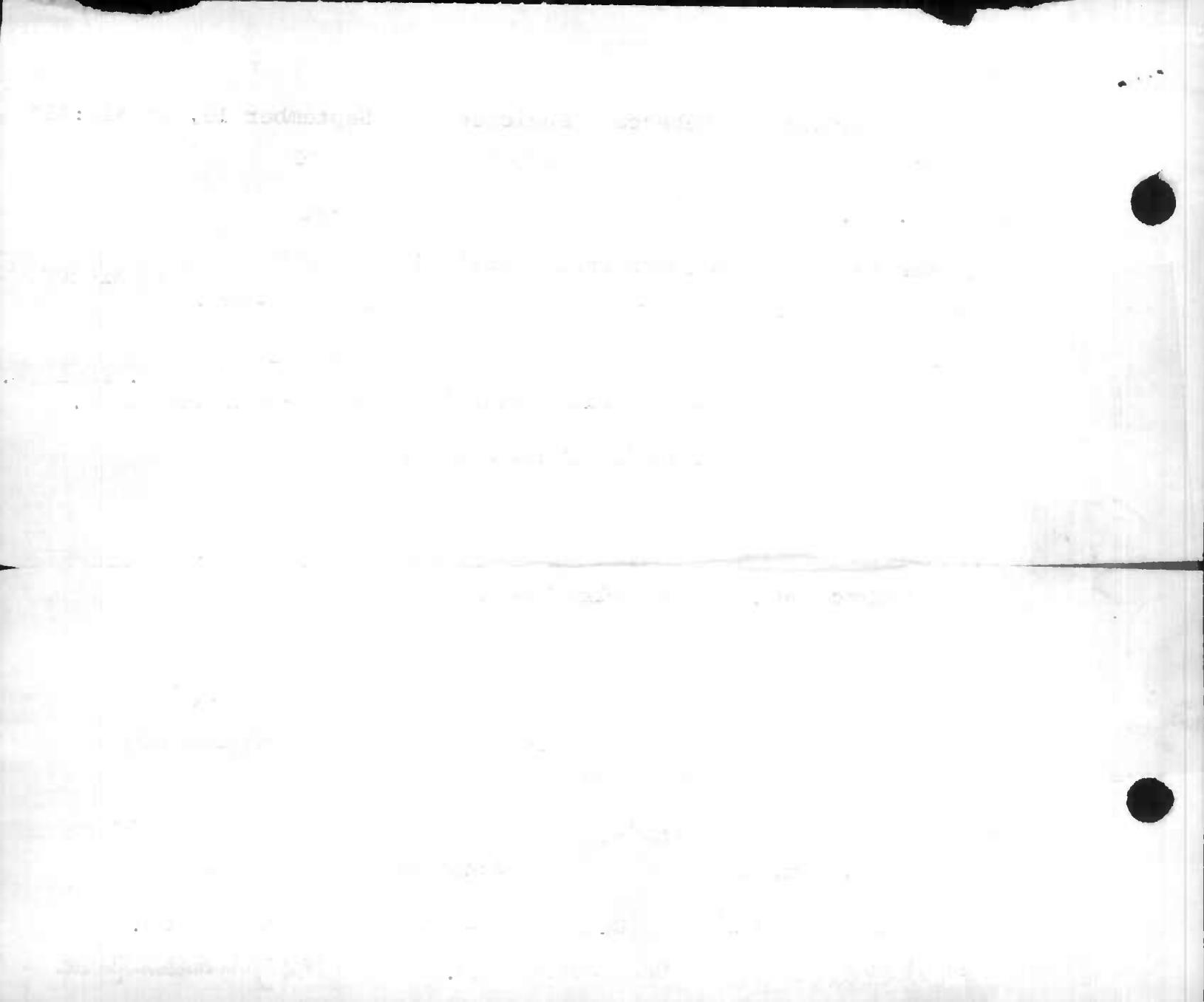
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 5 1 0 1	
1- STATE REGISTRAR		I. DECEASED NAME Helen X Maxx Campbell List REED											
2a. DATE KNOWN OF ESTIMATED DEATH		MONTH		DAY		YEAR		2b. HOUR					
2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa.												9. BALTIMORE CITY OR COUNTY OF DEATH Kent	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home Waterview Lane										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? NO		13e. STREET ADDRESS Bx 31 21620 RFD Waterview Lane		12b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME FIRST Walter		MIDDLE Gordon		LAST List		15. MOTHER'S MAIDEN NAME FIRST Kathryn T.		MIDDLE Campbell		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 166 09 1581		17. INFORMANT Gordon List		ADDRESS Waterview Lane Bx 31 Chestertown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) Deputy	
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr		ADDRESS Maryland 21620										MEDICAL EXAMINER	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE 10/1/84		23c. NAME OF CEMETERY OR CREMATORIAL Silverbrook Cem.		23d. LOCATION CITY OR TOWN Wilmington, Del.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Willis Well		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR OCT 4 1984		25b. REGISTRAR'S SIGNATURE Jane [Signature]							
DHMH - 17 (VR A15 ME (5)) 15M 2/80													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then use remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 25102	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST						
Nannie			Rebecca		Speicher		September 15, 1984			12:41 PM	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White		8-31-84		90				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.	
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 102 Campus Ave.	
14. FATHER'S NAME Milbourn Toulson							15. MOTHER'S MAIDEN NAME Sarah Bordley			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 220 44 1125		17. INFORMANT Sarah Buckingham - Baltimore, Md.			ADDRESS 4006 St. Paul St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Pulmonary Embolus</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Arteriosclerotic Cardiovascular Disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9-13, 1984, to 9-15, 1984, that (I) (we) last saw the deceased alive on 9-15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 			22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-20-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.			22e. ADDRESS Chestertown, Maryland		23d. LOCATION CITY OR TOWN Chestertown, Md.			23d. LOCATION CITY OR TOWN Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/17/84		23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		23d. LOCATION CITY OR TOWN Chestertown, Md.				
24. FUNERAL DIRECTOR NAME 			ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 24 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendell			
BP											
DHMH - 16 50M 4/83 (VRA 15, 4)											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

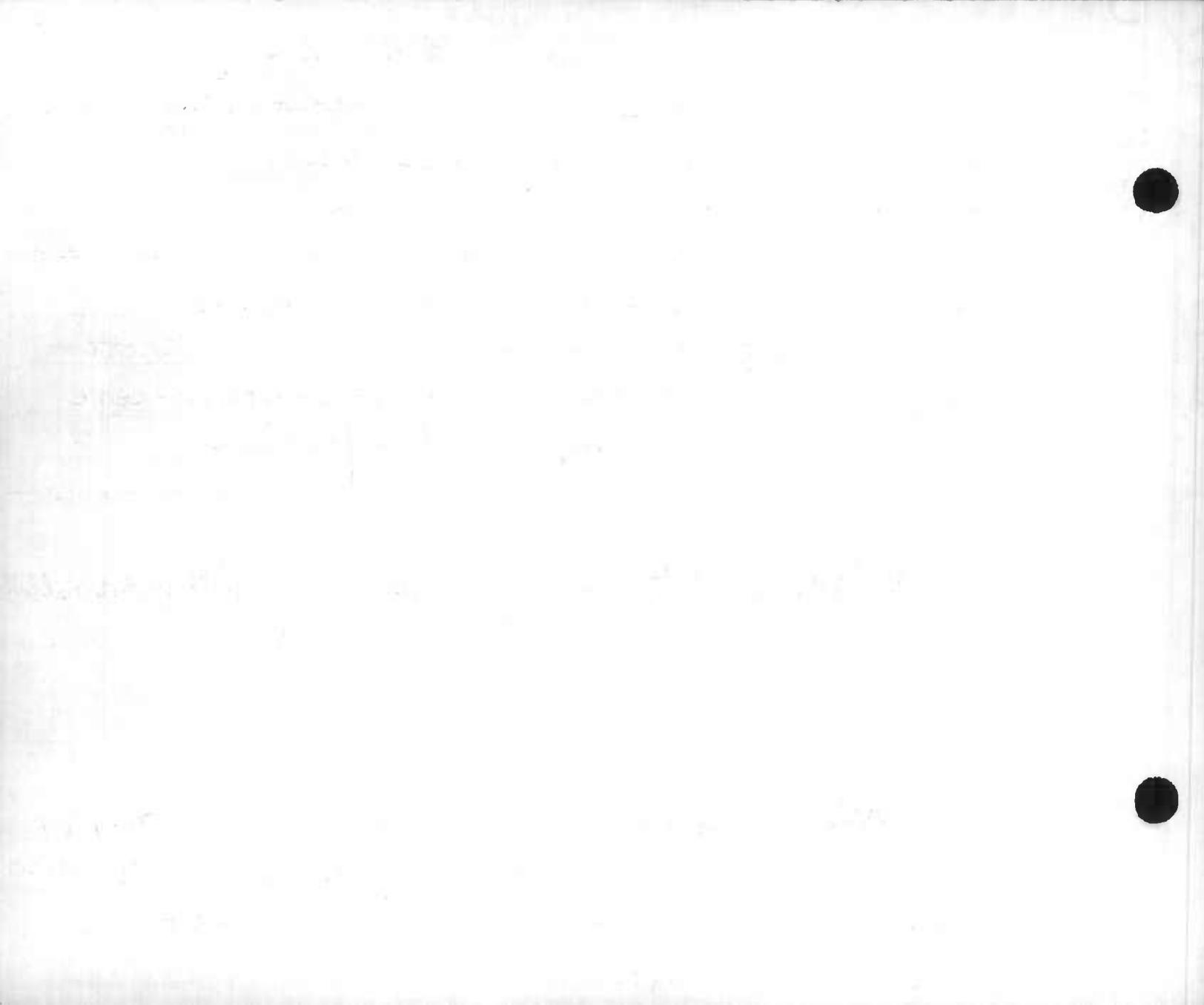
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25103							
1. DECEASED NAME (TYPE OR PRINT)				FIRST			MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Angeline Agnes VanSant												September 4, 1984					1:00 a.m.		
3. SEX Female				4. RACE White			5. DATE OF BIRTH MONTH October		DAY 11			YEAR 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County			
10 CITY OR TOWN OF DEATH Rock Hall				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At her home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper				12b KIND OF BUSINESS OR INDUSTRY MD.								
13a STATE Maryland		13b COUNTY Kent		13c CITY OR TOWN Rock Hall		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Sharp Street				21661							
14. FATHER'S NAME FIRST Nicholas G. Abbate				MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Barbara Schaefer				MIDDLE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 820-06-0508			17. INFORMANT				ADDRESS 21661								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) ACUTE LEUKEMIA															
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) —												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21f. LOCATION STREET —				CITY OR TOWN —		COUNTY —	STATE —					
22a. I certify that (I) (this hospital) attended the deceased from 8/20/84 to 9/4/84 , that (I) (we) last saw the deceased alive on 8/20/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE V.V.C.							
22c. DEGREE												ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 9/4/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Virginia Collier				22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 09/06/84			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION CITY OR TOWN Rock Hall		COUNTY Kent		STATE MD					
24 FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Homes, Chester, MD				25a. DATE REC'D. BY REGISTRAR SEP 13 1984								25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign it.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25104		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR September 28, 1984									2b. HOUR 2:53 A.M.		
1. DECEASED NAME (TYPE OR PRINT) Clara Virginia Walters			MIDDLE			LAST								
3. SEX FEMALE			4. RACE CAUC.			5. DATE OF BIRTH MONTH DAY YEAR APR. 29, 1922			6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GALENA MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			12b. KIND OF BUSINESS OR INDUSTRY HOME/FARM		
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			13a. STATE MD.			13b. COUNTY KENT		
13c. CITY OR TOWN GALENA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE JIM DAVIS RD 21635								
14. FATHER'S NAME FIRST JAMES			MIDDLE Deputy			LAST DANIS JR			15. MOTHER'S MAIDEN NAME FIRST FRANCES			MIDDLE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-20-4812			17. INFORMANT ADDRESS ADDIE WALTERS - HUSBAND - SAME								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last. (b) _____ (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Diabetes mellitus - Hyperlipidemia</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.														
22b. SIGNATURE <i>Robert Farr</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/29/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT FARR MD			22e. ADDRESS HIGH ST. CHESTERTOWN MD 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-1-84			23c. NAME OF CEMETERY OR CREMATORIAL Galen Cem			23d. LOCATION CITY OR TOWN GALENA KENT MD					
24. FUNERAL DIRECTOR NAME Fellows F.H.			ADDRESS M. Wellington, Md.			25a. DATE REC'D. BY REGISTRAR 10/5/84			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please return carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 25105			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			September 21 84		12:17 M	
Charles			Otto			Woyke									
3. SEX MALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH 7 DAY 11 YEAR 11			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS		IF UNDER 24 HRS HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY NEW YORK			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent			MD.			
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Building Contract			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 Telchester Hts 21620							
14. FATHER'S NAME FIRST FREDERICK WILHELM			MIDDLE 			LAST WOYKE			15. MOTHER'S MAIDEN NAME FIRST EMMA			MIDDLE MHN		LAST KLEIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 077-12-9610			17. INFORMANT IVA WOYKE (WIFE)			ADDRESS S MNR			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarcts, bilateral DUE TO, OR AS A CONSEQUENCE OF gave rise to immediate cause (b), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.															
19a. DATE OF OPERATION 9/21/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchoscopy for Hemoptysis			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) saw the deceased alive on Sept 21 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (and did not) view the body after death.			21d. LOCATION STREET CITY OR TOWN COUNTY STATE						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f.									
22a. I certify that (I) (this hospital) attended the deceased from 9:30 PM 9/20/1984 to 12:17 PM 9/20/1984 , that (I) (we) lost saw the deceased alive on Sept 21 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (and did not) view the body after death.															
22b. SIGNATURE David C. Donovan			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/21/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID C. DONOVAN M.D.			22e. ADDRESS Kent & Queen Anne's Hosp												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal & Burial			23b. DATE 9/25/84			23c. NAME OF CEMETERY OR CREMATORIAL Northport Rural Cemetery			23d. LOCATION CITY OR TOWN Northport L.I.N.Y.						
24. FUNERAL DIRECTOR NAME Wella Q. Fariss			25a. ADDRESS 29 S. Main St.			25b. DATE REC'D. BY REGISTRAR SEP 27 1984			25b. REGISTRAR'S SIGNATURE Jane Patterson-Nelson						
25a. ADDRESS Smyrna, Del.			25b. DATE REC'D. BY REGISTRAR SEP 27 1984			25b. REGISTRAR'S SIGNATURE Jane Patterson-Nelson									

